Complete Summary

GUIDELINE TITLE

Practice guideline for the treatment of patients with HIV/AIDS.

BIBLIOGRAPHIC SOURCE(S)

Practice guideline for the treatment of patients with HIV/AIDS. Am J Psychiatry 2000 Nov;157(11 Suppl):1-62. [473 references]

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Human immunodeficiency virus (HIV)/acquired immune deficiency syndrome (AIDS)

GUIDELINE CATEGORY

Management
Treatment

CLINICAL SPECIALTY

Infectious Diseases
Psychiatry

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

To assist the psychiatrist in caring for a patient with HIV/AIDS.

TARGET POPULATION

Primarily adults (over the age of 18) with HIV/AIDS or at risk for HIV infection.

INTERVENTIONS AND PRACTICES CONSIDERED

Psychiatric management of individuals who are at risk for HIV infection

1. Risk history
2. HIV antibody testing
3. Risk reduction (e.g., education, skill building, such as condom use), including strategies geared toward special populations (patients with substance use disorders or severe mental illness, and victims of sexual abuse/crimes)
4. Postexposure prophylaxis with antiretroviral medication when indicated

Psychiatric management and treatment of patients with HIV infection

5. Screening examination to determine whether neurocognitive deficits are present (mental status exam)
6. Therapeutic alliance
7. Collaboration and coordination of care with other mental health and medical providers
8. Facilitation of adherence to overall treatment plan
9. Education about psychological, psychiatric, and neuropsychiatric disorders
10. Risk reduction counseling to further minimize the spread of HIV
11. Strategies to maximize psychological and social/adaptive functioning
12. Inquiry regarding role of religion/spirituality
13. Preparation for issues of disability, death, and dying
14. Advice to significant others/family regarding sources of care and support
15. Sensitivity to sociodemographic variables (race/ethnicity, sexual orientation, gender, age, economic factors, urban versus rural) influencing treatment
16. Sensitivity to clinical features (suicidality, bereavement, Axis II disorders, psychoneuroimmunology) influencing treatment
17. Diagnosis, management, and treatment of all associated psychiatric disorders (dementia; delirium; mood disorders; substance use disorders; psychotic disorders; adjustment disorders; sleep disorders; disorders of infancy, childhood and adolescence; HIV-associated syndromes with psychiatric implications)
18. Pharmacologic treatment as indicated (antiretroviral therapy, antidepressant agents, antipsychotic medications, psychostimulants, mood stabilizers, anxiolytic and sedative-hypnotic medications, medications for HIV-related wasting, drugs used in the treatment of substance use disorders)

MAJOR OUTCOMES CONSIDERED

Not stated

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

A computerized search of the relevant literature from MEDLINE, PsycINFO, EMBASE, and AIDSLINE was conducted.

The first literature search was conducted by using MEDLINE for the period from 1966 to June 1998 and used the key words "acquired immunodeficiency syndrome," "HIV," "dementia," "mood disorders," "anxiety," "sleep," "depression mania," "substance use," and "adjustment disorders."

The literature search conducted by using PsycINFO covered the period from 1967 to March 1998 and used the key words "acquired immune deficiency syndrome," "adjustment disorders," "human immunodeficiency virus," "dementia," and "mood disorders."

The literature search conducted by using EMBASE covered the period from 1980 to 1998 and used the key words "acquired immune deficiency syndrome," "adjustment disorders," "human immunodeficiency virus," "mood disorders," "manic depressive psychosis," and "depression."

The literature search conducted by using AIDSLINE covered the period from 1980 to 1998 and used the key words "acquired immunodeficiency syndrome," "HIV," "adjustment disorders," "psychotherapy," "dementia," "treatment," "therapy," "therapeutic," and "mood disorders."

An additional literature search was conducted by using MEDLINE for the period from 1990 to 1999 and used the key words "correctional settings," "jail," "women," "minorities," and "suicide."

Additional, less formal, literature searches were conducted by American Psychiatric Association (APA) staff and individual members of the Work Group on HIV/AIDS.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus (Committee)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not applicable

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Once a topic is chosen for guideline development, a work group is formed to draft the guideline. By design, the work group consists of psychiatrists in active clinical practice with diverse expertise and practice experience relevant to the topic. Policies established by the Steering Committee guide the work of systematically reviewing data in the literature and forging consensus on the implications of those data, as well as describing a clinical consensus. These policies, in turn, stem from criteria formulated by the American Medical Association to promote the development of guidelines that have a strong evidence base and that make optimal use of clinical consensus.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Each recommendation is identified as falling into one of three categories of endorsement, indicated by a bracketed Roman numeral following the statement. The three categories represent varying levels of clinical confidence regarding the recommendation:

[I] indicates recommended with substantial clinical confidence.

[II] indicates recommended with moderate clinical confidence.

[III] indicates options that may be recommended on the basis of individual circumstances.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The guideline is written in successive drafts, each draft being revised based on comments received from an increasing number of people: early drafts are sent to the Steering Committee and about 50 expert reviewers; later drafts are sent to members of the Assembly, the District Branches, the Board of Trustees, and other American Psychiatric Association (APA) components. Drafts are available to all APA members by request through their District Branches. In addition, individual experts who are not APA members along with relevant professional, scientific, and patient organizations are asked to review the drafts. The development process for this guideline included comments from 12 organizations and over 60 individuals. Once all comments have been considered, a final draft is sent to the Assembly and Board of Trustees for approval. Thus, each guideline is reviewed by hundreds of psychiatrists and other interested parties prior to publication.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Each recommendation is identified as falling into one of three categories of endorsement, indicated by a bracketed Roman numeral following the statement. The three categories represent varying levels of clinical confidence regarding the recommendation:

[I] indicates recommended with substantial clinical confidence.

[II] indicates recommended with moderate clinical confidence.

[III] indicates options that may be recommended on the basis of individual circumstances.

Because psychiatric treatment of patients with human immunodeficency virus (HIV)/acquired immunodeficiency syndrome (AIDS) requires the consideration of many factors, it cannot be adequately reviewed in a brief summary. The reader is encouraged to consult the relevant portions of the original guideline document when specific treatment recommendations are sought. This summary is not intended to stand on its own.

Psychiatric management of individuals at high risk for HIV infection

Psychiatrists may encounter patients in the course of their clinical work who are at risk for acquiring HIV infection. Optimum management of patients at high risk for HIV infection uses a wide range of psychiatric skills such as comprehensive diagnostic evaluations, assessment of possible medical causes of new-onset symptoms, initiation of specific treatment interventions, and a keen understanding of psychodynamic issues [I]. Patients with substance use disorders, patients with severe mental illness, and victims of sexual abuse/crimes have specific risks for becoming infected with HIV [I]. Psychiatric management of individuals who,

because of specific behaviors, are at risk for HIV infection involves obtaining a risk history, considering the need for HIV antibody testing, initiating risk reduction strategies, and initiating postexposure prophylaxis with antiretroviral medication when indicated. A psychiatrist will not be aware of a patient's risk for HIV infection unless risk behavior is accurately assessed [I]. Psychiatrists should be knowledgeable about which specific risk behaviors are more likely to result in HIV transmission [I]. Psychiatric units or individual practitioners who conduct HIV testing should be aware of their obligation to provide the necessary pre- and posttest counseling [I]. Because successful risk reduction requires more than knowledge of risk, ongoing discussions between patient and psychiatrist can help provide the motivating and skill-building factors that help ensure consistent changes in behavior [II].

Psychiatrists serve as primary clinicians of both medical and psychiatric care in some institutional settings. Thus, administrators of these facilities should formulate policies that support the full range of HIV prevention steps outlined in this guideline [I]. Postexposure prophylaxis is recommended for known occupational exposure, especially percutaneous or mucous membrane exposure, to blood or other body fluids [I]. The American College of Obstetricians and Gynecologists now recommends that an HIV antibody test be offered during annual exams to all women seeking preconception care, not just pregnant women [II].

Psychiatric management of HIV-infected individuals

Specific tasks that constitute the psychiatric management of patients with HIV/AIDS include the following: establishing and maintaining a therapeutic alliance; collaboration and coordination of care with other mental health and medical providers; diagnosing and treating all associated psychiatric disorders; facilitating adherence to the overall treatment plan; providing education about psychological, psychiatric, and neuropsychiatric disorders; providing risk reduction strategies to further minimize the spread of HIV; maximizing psychological and social/adaptive functioning; considering the role of religion/spirituality; preparing the patient for issues of disability, death, and dying; and advising significant others/family regarding sources of care and support.

The development of a psychiatric treatment plan for patients with HIV infection requires thoughtful and comprehensive consideration of the biopsychosocial context of the illness [I]. When seeing a patient in consultation, it is important to gather history about cognitive or motor symptoms and conduct a mental status screening examination to determine whether neurocognitive deficits are present [I]. Psychiatrists should be knowledgeable about medication side effects and drug interactions of psychotropic agents as well as HIV-related medications in order to provide optimum patient care [I]. Psychiatric treatment of patients with HIV infection should include active monitoring of substance abuse, since it is often associated with risk behaviors that can lead to further transmission of HIV [I]. Adherence is of utmost concern with antiretroviral treatment because the regimens are so unforgiving; even minor deviations from the prescribed regimen can result in viral resistance and permanent loss of efficacy for existing medications [I]. Psychiatrists can play an important role in the promotion of patient adherence, since comorbid psychiatric disorders (e.g., substance abuse or

depression) have been shown to adversely affect patient compliance with a complicated treatment regimen [II].

Treatment of psychiatric disorders that result from or are comorbid with HIV infection

Psychiatric disorders associated with HIV/AIDS should be accurately identified and treated [I]. In adults and children with HIV infection, changes in mental status or the emergence of new psychiatric or cognitive disorders require ruling out treatable and reversible causes; medical causes are of increasing concern if CD4 counts are low or viral load has begun to rise [I].

The more common diagnoses found in association with HIV/AIDS are dementia and the spectrum of cognitive disorders; delirium; mood disorders; substance use disorders; anxiety disorders; psychotic disorders; adjustment disorders; sleep disorders; disorders occurring in infants, children, and adolescents; and HIV-associated syndromes with psychiatric implications. Both psychopharmacologic and psychotherapeutic treatment strategies are often indicated.

Treatment of HIV-associated dementia consists of intervening with combination antiretroviral therapy that targets the underlying HIV infection, with consideration of whether the agents adequately penetrate the central nervous system (CNS); management of symptoms associated with HIV-associated dementia (e.g., agitation or fatigue) with antipsychotic or stimulant agents, respectively, should be considered [I]. Delirium in the context of HIV infection may often be caused by interactions between the many medications taken by HIV patients. Management of delirium includes the judicious use of antipsychotic medications, with many clinicians choosing atypical agents because of their lower side effect profile; benzodiazepines are relatively contraindicated [II].

The management of disturbances in mood, such as major depression or mania, for patients with HIV infection is similar to that for other patients with medical comorbidity [I]. Choice of an antidepressant or mood-stabilizing agent may be influenced by the antiretroviral regimen in place, and dose adjustments may be necessary if drug-drug interactions are likely. A wide array of antidepressant agents are effective in the treatment of HIV-associated major depression, including newer agents such as the selective serotonin reuptake inhibitors (SSRIs) [I] and medications such as psychostimulants and testosterone [II]. Psychotherapy, particularly interpersonal psychotherapy, either alone or in combination with antidepressant agents, is also an effective treatment for HIV-related depression [II]. Mania associated with HIV infection, particularly late in the course of HIV disease, may be difficult to treat; however, treatment studies suggest that traditional antimanic agents are effective and tolerated [II].

The constellation of other disorders associated with HIV infection require treatment. Substance use disorders are prevalent among persons with or at risk for HIV infection, and treatment is a high priority [I]. Psychiatrists should be aware that by treating substance abuse, they may well be preventing HIV infection. One component of a comprehensive approach to HIV prevention among injection drug users is access to sterile syringes [I]. Treatment of anxiety and sleep disorders among HIV-infected patients has not been well studied. For patients who are taking protease inhibitors, benzodiazepines are generally

contraindicated because of drug-drug interactions [II]. Thus, benzodiazepines should be given only as a short-term intervention in most instances. Psychotic symptoms in late-stage HIV infection are generally managed with atypical antipsychotic medications at the lowest effective dose, since standard neuroleptic medications have been associated with severe and difficult-to-treat extrapyramidal side effects [I]. Adjustment disorders may require treatment with psychotherapy or medication to prevent progression to a more severe psychiatric disturbance [III]. HIV-associated syndromes with psychiatric implications encompass wasting syndrome, fatigue, pain, and sexual dysfunction. Wasting syndrome has been effectively treated with testosterone (or its derivatives), growth hormone, and thalidomide [I]. Psychostimulants are one of the main interventions used for fatigue [II]. Chronic pain from peripheral neuropathy is often treated with tricyclic antidepressants and anticonvulsant medications, but published treatment studies of pain syndromes in patients with HIV infection have not supported their use [III]. In men, HIV-related hypogonadism can be treated with testosterone replacement [II].

Treatment of children and adolescents with antiretroviral medications has increased survival rates and slowed progression to AIDS [I]. The effectiveness of treatment of other mental and behavioral disorders associated with HIV infection in children and adolescents is largely unstudied.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The recommendations delineated in this guideline are in some instances based on data distilled from randomized prospective clinical trials, while in other areas they are based on individual case reports along with the collective experience and judgment of well-regarded senior psychiatrists.

To identify the type of evidence supporting the major recommendations in the full-text practice guide, each is keyed to one or more references and each reference is followed by a letter code in brackets that indicates the nature of the supporting evidence. Minor recommendations not keyed to references may be assumed to be based on expert opinion.

The bracketed letter following each reference indicates the nature of the supporting evidence, as follows:

[A] Randomized controlled clinical trial

[B] Nonrandomized case-control study

[C] Nonrandomized cohort study

[D] Clinical report with nonrandomized historical comparison groups

[E] Case report or series

[F] Expert consensus

[G] Subject review subsuming multiple categories A-E

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Appropriate psychiatric management of patients with human immunodeficency virus (HIV)/acquired immunodeficiency syndrome (AIDS) or patients at risk of HIV.
- Preventing HIV infection in psychiatric patients.

POTENTIAL HARMS

- Adverse events and side effects of medication used to treat human immunodeficency virus (HIV), HIV-related conditions, or psychiatric conditions in HIV infected individuals.
- Potential drug-drug interactions (for example, antiretroviral medications and psychotropic medications).

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The American Psychiatric Association develops derivative products including patient guides, quick reference guides, continuing medical education questions, and quality of care indicators with research studies to evaluate the effectiveness of the guideline.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness
Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Practice guideline for the treatment of patients with HIV/AIDS. Am J Psychiatry 2000 Nov;157(11 Suppl):1-62. [473 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2000 Nov

GUIDELINE DEVELOPER(S)

American Psychiatric Association - Medical Specialty Society

SOURCE(S) OF FUNDING

American Psychiatric Association (APA)

GUIDELINE COMMITTEE

Work Group on HIV/AIDS

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Work Group Members: J. Stephen McDaniel, (Chairperson) MD; Joyce Y. Chung, MD; Larry Brown, MD; Francine Cournos, MD; Marshall Forstein, MD; Karl Goodkin, MD, Ph.D, Constantine Lyketsos, MD, MHS

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

The guideline will be considered current, unless the guideline developer publishes revisions or a withdrawal.

GUIDELINE AVAILABILITY

Electronic copies: Available from the American Psychiatric Association's Web site.

Print copies: Available from the American Psychiatric Press, Inc (APPI), 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209-3901; (703) 907-7322; (800) 368-5777; Fax (703) 907-1091.

AVAILABILITY OF COMPANION DOCUMENTS

The following is available:

- American Psychiatric Association practice guideline development process. In: Practice Guidelines for the Treatment of Psychiatric Disorders: Compendium 2000. Washington, DC: APA, 2000.

Print copies: Available from the American Psychiatric Press, Inc (APPI), 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209-3901; (703) 907-7322; (800) 368-5777; Fax (703) 907-1091.

Ordering Information:

- 2000/768 pages/ISBN 0-89042-315-6/paperback/ $49.95/Order #2315
- 2000/768 pages/ISBN 0-89042-312-1/hardcover/ $64.95/Order #2312

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on February 1, 2001. The information was verified by the guideline developer as of March 9, 2001.

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